SECOND EDITION

A Textbook of Community Nursing

EDITED BY

SUE CHILTON and HEATHER BAIN

- PRACTICAL AND EVIDENCE-BASED
- LEARNING OBJECTIVES, EXERCISES AND ACTIVITIES
- CASE STUDIES AND EXAMPLES FROM PRACTICE

ROUTLEDGE

A Textbook of Community Nursing

A Textbook of Community Nursing is a comprehensive and evidence-based introduction covering the full range of professional topics, including professional approaches to care, public health, eHealth, therapeutic relationships and the role of community nursing in mental health. The new edition has been updated throughout, including new guidelines and policies. It also provides a stronger focus on evidence-based practice.

This user-friendly and accessible textbook includes the following:

- Current theory, policy and guidelines for practice. All chapters are underpinned by a strong evidence base.
- Learning objectives are provided for each chapter, plus exercises and activities to test current understanding, promote reflective practice and encourage further reading.
- Case studies and examples from practice which draw on all branches of community nursing are provided to illustrate practical application of theory.

This is an essential text for all pre-registration nursing students, students in specialist community nursing courses and qualified nurses entering community practice for the first time.

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A Textbook of Community Nursing

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FOREWORD

All four countries of the United Kingdom recognize that nurses are leading and supporting the implementation of the shared policy imperative for more care to be delivered in or closer to the home.

This comprehensive book confirms the critical and evolving role of the nurse in the community in supporting individuals, families and carers at every stage of their lives.

The themes of each chapter illustrate both the rapidly changing policy context of care in the community and the political, economic, scientific and technical developments that have influenced and supported the growth of the nurse's role.

There could not be a better time to work in the community, as this book illustrates so clearly; autonomous roles, leadership of teams and the potential to care for acutely ill patients in their own homes are just some examples which demonstrate the range of advanced level, specialized skills now required.

There is also a clear recognition that with this responsibility there is a need for the underpinning high level of nursing knowledge which includes asset- and strength-based approaches to care, a demonstration of cultural competence and a considerable level of understanding concerning the social determinants of health.

In the world of healthcare today, there is an expectation that people will take a greater part in decisions about their health and in managing their healthcare. Consideration of what it is to be a professional in this current context is therefore important – but also serves as a reminder of the privilege of working with individuals and communities and the trusting, often long-term therapeutic relationships that are developed and maintained.

For those who are new to nursing in the community there is a coverage of holistic assessments, a nursing practice that involves a person-centred, partnership approach and includes addressing the spiritual needs of patients. The central role of carers and the nurses' role in supporting adult and young carers are given a high profile. This is significant as carers frequently provide the majority of care for patients, and yet their role so often goes unrecognized.

Collaborative working has always been important to nurses working in the community. There is now an imperative to working with colleagues in the voluntary, social and healthcare systems in a more integrated way. New service models provide many opportunities for this and nurses are experts at building relationships with others to the benefit of the patient, family and carers.

With people living increasingly longer lives – which is a cause for celebration – there is a consequent increase in those living with long-term conditions. It is excellent to see a focus on the principles of long-term condition management within the current policy context and the pivotal role of the nurse in the community setting.

A focus on the nurse's central role and the skills required to provide high-quality care in the home at the end of life is given the attention it rightly deserves. There is

an often forgotten army of nurses who provide a critical service in the co-ordination and delivery of care for patients at the end of their lives, every day. This happens in every village, town and city around the United Kingdom and yet is rarely given the attention it deserves in the media.

The ways in which nursing is embracing technology to enhance patient care are illustrated in their leadership of new ways of working and a nuanced understanding of patients' responses to such opportunities.

Reading this cleverly woven set of chapters provides a reminder of the unique combination of autonomous and team working that is the joy of serving a community as a highly skilled, creative and resourceful nurse. It provides essential reading to those who are new to a rewarding nursing career in the community and a welcome invigoration for those nurses who have been privileged to serve their communities for many years.

Dr Crystal Oldman
Chief Executive
The Queen's Nursing Institute

INTRODUCTION

Sue Chilton and Heather Bain

This book has been designed to support staff who may be new to working in a community setting and is an essential guide to practice. We envisage that it will be useful for pre-registration students on community placement, community staff nurses and nurses moving from an acute work environment to take up a community post. The aim of the book is to develop and support nurses to work safely and effectively in a range of community locations.

Community nurses work in a great diversity of roles and a variety of settings – including schools, the workplace, health clinics and the home (Naidoo and Wills, 2016). They empower individuals, families and communities to have control over their health and to improve their wellbeing. They also work across the lifespan, and with a range of social groups that include those who are vulnerable, experience inequalities and are socially excluded. Not only do community nurses work autonomously in leading, managing and providing acute and long-term health and social care, anticipatory care and palliative care, but they also have a public health remit. They have a pivotal role in health protection, ill-health prevention and health improvement.

Community practice is dynamic, forever changing and in a constant state of flux. Baguley et al. (2010) have conceptualized community nursing in Figure I.1, which illustrates that, in the promotion of optimum health and wellbeing, community

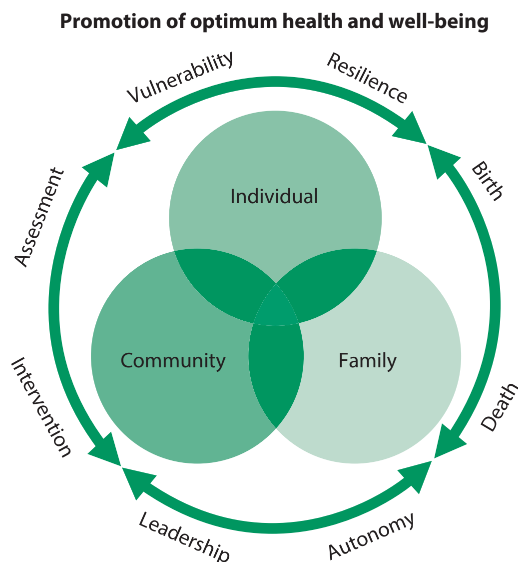

FIGURE I.1 Promotion of optimum health and well-being. (Reproduced from Baguley et al., *Concept of Community Nursing*, Aberdeen: Robert Gordon University, 2010.)

practitioners work in a range of locations – with individuals, families and communities. The overlapping spheres demonstrate the intricacies and relationships between individuals, families and communities.

Community nursing is complex but essentially falls within the following four continuums, which are all addressed within this book:

- Birth to death: They work with all ages across the lifespan.
- Vulnerability and resilience: Individuals, families and communities fluctuate in and out of vulnerability and resilience throughout their life.
- Assessment and intervention: Community practitioners work within a cycle of assessment of needs and interventions to address the needs and support individuals, families and communities.
- Leadership and autonomy: Community practitioners work in varying degrees of autonomy and leadership in advancing practice, evidencing practice and providing the best practice.

A range of topics relating to professional issues in community nursing is addressed within the book. The text reflects recent and current government health and social care policy reforms and the effect of these on the roles and responsibilities of community nurses. It is acknowledged that the devolution of political power to the four countries within the United Kingdom has influenced health policies. There is now a much greater degree of freedom in relation to the health policies they produce. All recognize the shifting balance of care from the acute sector to the community, with an increasing focus on the management of long-term conditions to reduce hospital admissions. There are, however, various political stances providing differing opinions on how to develop their own health services that take the demographics of each of the four countries into consideration (Timmins, 2013).

Community nursing is seen in the context of not only political but also social and environmental influences. The authors take an inclusive approach, working from a health and social care perspective to meet the needs of service users. Interpersonal and practical skills, as well as the knowledge base required by community nurses, are critically analyzed and linked to relevant theory. The use of activities, examples and case studies/scenarios relating to the range of community nursing disciplines are included throughout the book to stimulate the reader's creative thinking. Themes running through the text are evidence-based practice, reflection, vulnerability and current government policy drivers across the four UK countries. Each chapter has been written by a contributor(s) with in-depth knowledge and experience of the specific subject area, resulting in a range of writing styles.

Topics covered within this text inform key aspects of the community nurse's role. A brief summary of each chapter is detailed below:

Chapter 1 – *Nursing in a community environment* – Explores definitions of 'community' and acknowledges its complex nature. A range of factors influencing the delivery of community healthcare services and the expertise required of community nurses is discussed.

Chapter 2 – *Public health and the promotion of well-being* – Analyses the role of public health in community nursing and ways of determining health needs. Opportunities for positively influencing care delivery are explored.

Chapter 3 – *Professional approaches to care* – Discusses the concept of 'professionalism', comparing and contrasting the traditional, hierarchical and individualistic model of professional practice with a more inclusive partnership model.

Chapter 4 – *Managing risk* – Explores health and safety considerations in relation to community nursing with particular emphasis upon vulnerable groups – people with mental health issues, older people and children.

Chapter 5 – *Therapeutic relationships* – Discusses the challenges and issues involved in establishing therapeutic relationships between service users and community nurses.

Chapter 6 – *Care across the lifespan* – Considers how an understanding of the lifespan can enhance the quality of care provision by exploring different theories of growth and development.

Chapter 7 – *Community nursing assessment* – Explores the notion of 'assessment' and the concept of need. Assessment frameworks and decision-making processes are discussed.

Chapter 8 – *The role of the community nurse in mental health* – Explores the relationship between physical and mental health. The roles of the community nurse in mental health assessment and associated interventions are examined.

Chapter 9 – *Carers: The keystone of communities and families* – Discusses the role of carers identifying some of the inherent challenges and rewards. Carer assessment tools and carer support networks are considered.

Chapter 10 – *Spirituality: A neglected aspect of care* – Highlights the importance of developing self-awareness and using appropriate tools to assess and address a person's spiritual needs.

Chapter 11 – *Collaborative working: benefits and barriers* – Examines the importance of collaborative working including some of the opportunities and constraints.

Chapter 12 – *Approaches to acute care in the community* – Defines acute care in the community setting and identifies the knowledge and skills required by community nurses to manage it.

Chapter 13 – *Emerging issues in long-term conditions* – Describes contributing factors and the potential impact of a long-term condition on individuals, families and communities.

Chapter 14 – *Providing quality care at the end of life* – Highlights the importance of a holistic and timely assessment in order to effectively manage the end-of-life care needs.

Chapter 15 – *Organisation and management of care* – Critically analyzes work organisation and care delivery in the community setting with particular reference to prioritization, delegation and skill mix.

Chapter 16 – *Leading quality, person-centred care in the community* – Explores the role of leadership and clinical governance at practice level within community nursing.

Chapter 17 – *eHealth* – Defines the terminology used in telehealth and telecare and appraises its potential use in community nursing practice.

Chapter 18 – *Development of community nursing in the context of changing times* – Identifies contemporary political influences and discusses new ways of working and responding as community nurses.

Within each chapter, further reading and resources are suggested. We hope you find this book informative and inspirational in developing your professional practice.

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CHAPTER

1

Nursing in a community environment

Sue Chilton

LEARNING OUTCOMES

- Compare and contrast definitions of 'community', exploring the contexts in which the term is used and, specifically, how it is interpreted within community nursing.
- Explore the environmental, social, economic, professional and political factors influencing the delivery of community healthcare services and critically appraise ways in which local services aim to be responsive to the specific needs of their population.
- Develop insight into the complex nature of the environment of community healthcare.
- Identify the skills and qualities required of nurses working in community settings.

INTRODUCTION

This chapter considers the complex environment within which community nurses practice and offers some definitions of 'community' and ways in which the term is used. It explores the wide range of factors impacting upon the services community nurses provide for patients and discusses ways of tailoring care to respond to local needs. Key skills and qualities currently required by community nurses are identified and discussed.

DEFINITIONS OF 'COMMUNITY'

Changes in terms of the location and nature of community nursing care provision have occurred over the years in response to a variety of influencing factors. More recently, we have seen a distinct shift of services from the hospital setting to primary care and community locations (Turnbull, 2017; McGarry, 2003). Current health and social care policy directives indicate that still more services will be provided within the community context in the future (Scottish Government, 2013; Welsh Assembly Government, 2013; Scottish Government, 2010; DHSSPSSNI, 2011; NHS England, 2014). In order to provide the required administrative and managerial infrastructure to accommodate these changes, several major organisational reconfigurations have

taken place across the United Kingdom in recent years. In England, for example, general practitioner (GP) fundholding was replaced by primary care groups, which then developed into primary care trusts (DH, 1997). Further changes quickly followed with the largest structural reorganisation of the National Health Service (NHS) since its inception in 1948, involving the development of GP consortia (DH, 2010a), which have wide-ranging responsibilities for commissioning services and manage the vast majority of the NHS budget. Over the last few months, there has been the development of 'Sustainability and Transformation Plans' (STPs) which involve partners working together in 'place-based systems of care' to transform health and social care delivery within local populations. These plans are focused on improving quality and developing new ways of working; improving health and well-being; and improving the efficiency of services in hospitals and the community (Alderwick et al., 2016). Political analysts have recognised the potential value of STPs in supporting new care models and promoting collaboration between key stakeholders but also advise caution and the need for close monitoring and evaluation in testing whether service changes and related financial plans are viable (King's Fund, 2017).

Although, from an academic perspective, the notion of 'community' has been discussed widely across a range of disciplines, including sociology and anthropology (Cohen, 1985), clarity with regard to a definitive definition eludes us.

ACTIVITY 1.1

Reflection point

Compile a list of words that helps to define 'community' for you. Identify any recurring themes that emerge when considering different types of communities or different contexts within which the term is used.

Laverack (2009) offers four key characteristics of a 'community' which help to summarise many of the definitions found in the literature. These are as follows:

- Spatial dimension – referring to a place or location
- Interests, issues or identities that heterogeneous groups of people share
- Social interactions that are often powerful in nature and tie people into relationships or strong bonds with each other
- Shared needs and concerns that can be addressed by collective and collaborative actions

Although the essence of 'community' is difficult to capture within a definition, the word itself largely conveys a positive impression conjuring up feelings of harmony and co-operation. It is unsurprising to find that it is a word used frequently by politicians within government documents to create just that effect.

The uncertainty with regard to the true meaning of the word 'community' also applies within community nursing (Hickey and Hardyman, 2000). It is pivotal (Carr, 2001) that the context within which care takes place, including physical and social aspects among many others, is considered alongside the geographical

location of care. By attempting to include the wide array of elements involved, the true complexity of nursing within the community begins to emerge. Although some of the challenges, such as interacting with patients and families in their own homes, are acknowledged within the literature (Luker et al., 2000; Quaile, 2016a), the meaning of 'community' within community nursing is often assumed and taken for granted (St John, 1998).

St John (1998: 63) interviewed community nurses who explained the nature of the communities they worked within in terms of 'geography; provision of resources; a network and target groups'. Some nurses described their communities as a 'client' or an entity, particularly where members of the community were connected. If a population was not connected, nurses defined community as the next largest connected element such as a group or family.

It would appear, therefore, that definitions of community often include the dimensions of people, geography or space and shared elements, relationships or interests and incorporate some form of interaction. Many of these common themes are captured in the following definition of 'community' as

> ... a social group determined by geographical boundaries and/or common values and interests. Its members know and interact with each other. It functions within a particular social structure and exhibits and creates certain norms, values and social institutions.
>
> (*WHO, 1974*)

Awareness of the networks that exist within a community helps in identifying opportunities or strategies to engage 'hidden' members of the population. 'Social capital' is a term used to explain networks and shared norms that form an essential component of effective community development (Wills, 2009). It is proposed that poor health is linked to low social capital and social exclusion where poverty or discrimination exist (Wilkinson, 2005). According to the National Occupational Standards in Community Development Work, the main aim of community development work is

> collectively to bring about social change and justice by working with communities to identify their needs, opportunities, rights and responsibilities; plan, organise and take action and evaluate the effectiveness and impact of the action all in ways which challenge oppressions and tackle inequalities.
>
> (*Lifelong Learning UK, 2009*)

Community development work is inclusive, empowering and collaborative in nature and is underpinned by the principles of equality and anti-discrimination, social justice, collective action, community empowerment and working and learning together.

A study by McGarry (2003) identifies the central position of the home and relationships that take place within it in defining the community nurse's role. Four key themes emerging from her research are 'being a guest' within the home, the

maintenance of personal-professional boundaries, notions of holistic care and professional definitions of community. The findings highlight the tensions for nurses in embracing their personal perceptions of community nursing while trying to work effectively within the constraints of organisational and professional boundaries.

Kelly and Symonds (2003), in their exploration of the social construction of community nursing, discuss three key perspectives of the community nurse as carer, the community nurse as an agent of social control and community nursing as a unified discipline. The authors discuss the proposition that community nurses are still reliant on others to present the public image of community nursing that is portrayed. They argue, interestingly, that community nurses may not possess enough autonomy to define their own constructs and articulate these to others.

Community Links is a charitable organisation which, through its national work, shares lessons with government and community groups across the country to achieve social change. The charity's chief executive, Blake, believes the concept of community has become more complex and that a top-down or narrow definition may not be useful and can, in certain instances, have negative consequences. According to Blake (2013), community is a 'fluid, chaotic thing' and defining the concept is not essential and adds that 'It's the doing something together that is important'. People can belong to many different communities whether based on geography, ethnicity, religion, interest or other social factors such as disability or refugee status and this notion of multiple communities can strengthen and add value to communities. In addition, communities are not static and can change over time, presenting challenges to service providers who may need to adapt their interventions depending on the expressed needs of a community at any one time (Niven, 2013).

Niven (2013) interviewed five community leaders from different charitable and voluntary organisations and found that, although community identity is difficult to conceptualise, these leaders sensed that a strong desire from the public to be part of a community is returning.

FACTORS INFLUENCING THE DELIVERY OF COMMUNITY HEALTHCARE SERVICES

Community nurses face many challenges within their evolving roles. The transition from working in an institutional setting to working in the community can be somewhat daunting at first (Sines et al., 2013a). As a student on community placement or a newly employed staff nurse, it soon becomes apparent that there is a wide range of factors influencing the planning and delivery of community healthcare services. Within the home/community context, those issues that impact upon an individual's health are more apparent. People are encountered in their natural habitats rather than being isolated within the hospital setting. Assessment is so much more complex in the community, as the nurse must consider the interconnections between the various elements of a person's lifestyle. Chapter 7 explores the concept of assessment in more detail. In addition, community nurses are often working independently,

making complex clinical decisions without the immediate support of the wider multidisciplinary team or access to a range of equipment and resources as would be the case in a hospital or other institutional healthcare environment. It is recognised, for example, that district nurses are frequently challenged with managing very complex care situations which require advanced clinical skills, sophisticated decision making and expert care planning (Quaile, 2016a). Ford (2016) also acknowledges the need for specialist district nurse practitioners to have expert knowledge and advanced clinical skills as well as highly developed interpersonal skills and a clear understanding of a whole systems approach.

Defining health is complex as it involves multiple factors. According to Blaxter (1990), health can be defined from four different perspectives: an absence of disease, fitness, ability to function and general well-being. The concept of health has many dimensions such as physical, mental, emotional, social, spiritual and societal. All aspects of health are interdependent in a holistic approach. It is prudent to view individuals within their wider context, when considering issues relating to their health and well-being to ensure that relevant social determinants are taken into account (Figure 1.1).

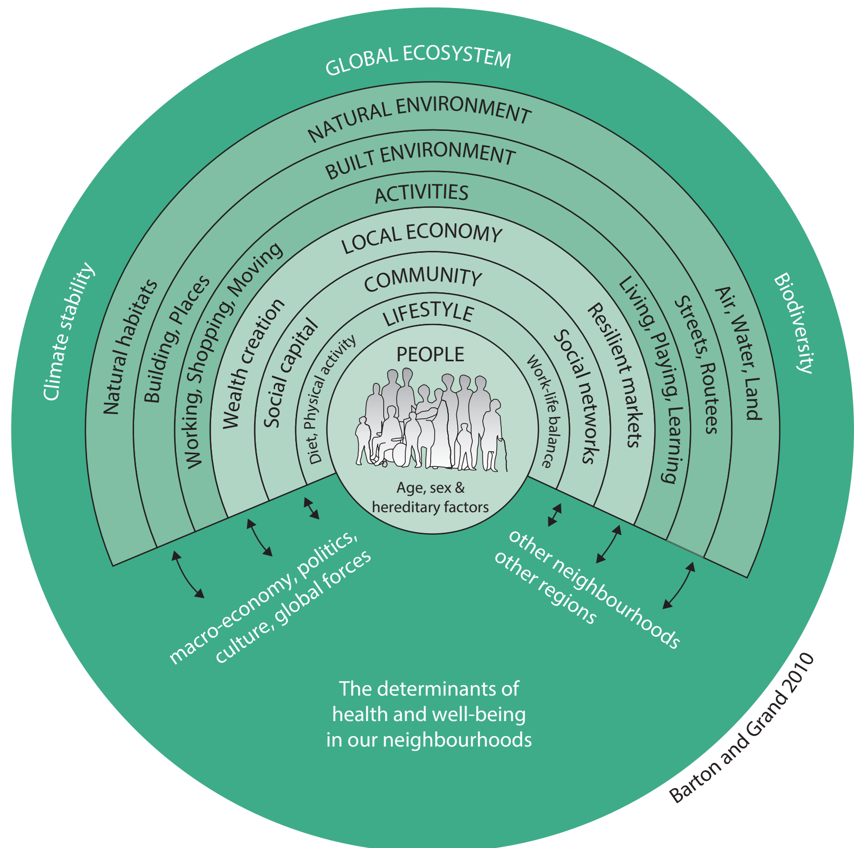

Figure 1.1 The health map. (From Barton H and Grant M., *Journal of the Royal Society for the Promotion of Health*, 126, 152–253, 2006.) The determinants of health and well-being in our neighbourhoods.

There are acknowledged inequalities in health status between different people within society and major determinants include social class, culture, occupation, income, gender and geographical location. Health inequalities were highlighted and 'put on the map' in the Black Report of 1980 (DHSS, 1980) and relate to the difference between groups or populations defined socially and demographically that are unfair, avoidable and remedial rather than innate differences between groups (Gillam et al., 2012). Several reports have been published since the 1980s, across the countries making up the United Kingdom, providing comprehensive reviews of the literature/research available on inequalities in health (DHSS, 1980; Acheson Report, 1998; *Marmot Review*, 2010; Welsh Government, 2014 DHSSPSNI, 2014; Scottish Government, 2016). Although these documents have sought to inform the national public health agenda of the day, the reality is that unacceptable inequalities remain.

Health inequalities are not random but related to the 'social gradient' in health: geographical locations with high levels of income deprivation typically have lower life expectancy. This relationship is referred to as the 'Marmot Curve' in the independent and influential report in England, *Fair Society, Healthy Lives* (*Marmot Review*, 2010). The main recommendations of this report are as follows:

- Giving every child the best start in life
- Enabling all children, young people and adults to maximise their capabilities and have control over their lives
- Creating fair employment and good work for all
- Ensuring a healthy standard of living for all
- Creating and developing healthy and sustainable places and communities
- Strengthening the role and impact of ill-health prevention

Disadvantaged children in Britain continue to experience poorer health outcomes than their wealthier counterparts, including increased levels of obesity and mental health conditions, and, according to child health experts, their future health and happiness are in jeopardy as a result (Royal College of Paediatrics and Child Health, 2017).

The *Marmot Review* (2010) states that people living in more disadvantaged communities die 7 years earlier on average than people living in more prosperous communities. Those in the poorest neighbourhoods will also experience more of their lives with a disability – an average difference of 17 years.

Bambra (2016), a leading expert in public health, draws on case studies from across the world to examine the social, environmental, economic and political causes of health inequalities, how they have evolved over time and what they are like today.

In order to improve health inequalities, Marmot (2010) suggests that health professionals, including community nurses, can contribute in three ways. First, they can help to remove any social and ethnic barriers to receiving healthcare. Second, they should act as advocates for their service users and work in collaboration with other health and social care providers. Finally, they should base health improvement

initiatives/best practice on rigorous evidence and research so that strategies used are effective and replicable. In response to this, the DH (2010b) recognises that disadvantaged areas face the toughest challenges and are set to receive greater rewards for any health improvements made.

Buck and Maguire (2015) advocate a more nuanced and integrated policy response and state that, although there is some evidence of integration, an approach to health inequalities delivered through population health systems that clearly integrate NHS services with other public health services and public health initiatives is required.

Although there is some evidence of positive findings over the 2000s, continuing austerity will inevitably have consequences for health inequalities. In addition, it is essential that the implementation of policy at community level needs to reflect local knowledge, history and experience if it is to be realistic and effective (Buck and Maguire, 2015).

Chapter 2 explores key concepts relating to public health and health inequalities in greater detail.

The increased emphasis lately on the development of a primary care–led NHS has come about in response to demographic, technological, political and financial influences, among others. An increasing population of older people, shorter hospital stays, improvements in technology and patient preference have all contributed to the advocated movement of resources from the acute to the primary care sector.

The development of new competencies to provide services away from hospital settings means that an increasing number of people with both acute and long-term conditions will eventually receive care at home or in a range of other locations within the community. It is envisaged that hospitals will mainly provide diagnostic and specialist services in the future (NHS England, 2014).

If the aims of current policy directives are to be realised, plans to address the 'triple fragmentation' – between health and social care, primary and secondary care and physical and mental health services – as described by Stevens (2016) will need to be a priority (King's Fund, 2017).

MEETING THE NEEDS OF THE LOCAL POPULATION

Community nurses can identify the needs of their given population by conducting a health needs assessment, which is a process of gathering information from a variety of sources in order to assist the planning and development of services. As society is constantly changing, health needs assessment is not a static exercise.

The National Institute for Health and Care Excellence (NICE, 2017) defines 'health needs assessment' as

> A systematic process used by NHS organisations and local authorities to assess the health problems facing a population. This includes determining whether certain groups appear more prone to illness than others and pinpointing any inequalities in terms of service provision. It results in an agreed list of priorities to improve healthcare in a particular area.

Buck and Gregory (2013) recognise the need for a clear purpose and 'robust local framework based on outcomes-focused partnerships and commitment to systematic health impact assessment' to improve the public's health and tackle health inequalities. To this end, information is required regarding disease patterns (epidemiology) and public health in a particular area (locality/community/neighbourhood) as well as data regarding local environmental factors/resources (knowledge base/experience of community service providers), in other words, a combination of 'hard' (statistical/research-based/quantitative) data and 'soft' (experiential/anecdotal/qualitative) data.

Qualitative information may include newspapers; meetings of agencies; diaries, meeting notes of local workers; projects undertaken by students on programmes of study; photographs and videos. Quantitative data will be obtained from a variety of sources but will consist mainly of statistical evidence and research-based studies (Hawtin and Percy-Smith, 2007).

Three key approaches to health needs assessment described by Coles and Porter (2008) are epidemiological, comparative and corporate. A comprehensive assessment would normally incorporate more than one of these approaches.

ACTIVITY 1.2

Reflection point

Consider the area/team within which you are working at present. What sources of information would help inform you of the specific needs of your client group/population? Make a list and try to divide the information into either 'hard' or 'soft' data.

Explore the different sources of data available to inform a health and social needs assessment of your local community. Much information can be obtained from the local council, libraries and Internet sources (see Further Resources list).

In capturing the 'essence' of a locality, the term 'community profile' is frequently used to describe an area in relation to its amenities, demography (characteristics of the population), public services, employment, transport and environment. Traditionally, health visitors, in particular, have been required to produce community profiles as a form of assessment during their training.

'Community profiling' can be defined as

> a comprehensive description of the needs of a population that is defined, or defines itself, as a community and the resources that exist within that community, carried out with the active involvement of the community itself, for the purpose of developing an action plan or other means of improving the quality of life of the community.
>
> (*Hawtin and Percy-Smith, 2007: 10*)

There are three interacting levels identified within profiling, which are

- Community – Assessment of need within a locality/neighbourhood
- Practice – Assessment of need within a GP practice
- Caseload – Assessment of need within a health professional's caseload

Any attempt to analyse the series of complex processes that makes up a living community without the participation of local residents/consumers is a fairly fruitless exercise. In gathering information from a large community population, a variety of methods may prove useful. An approach entitled Participatory Rapid Appraisal has been described elsewhere (Coles and Porter, 2008) and involves community members in the collection of information and related decision making. Originally used in developing countries to assess need within poor rural populations, it has been employed in deprived urban areas. A wide variety of data-collection methods is used and Participatory Rapid Appraisal involves local agencies and organisations working together. By working in partnership with local residents, action is taken by community members who have identified issues of local concern/interest and discussed potential solutions. Clearly, Participatory Rapid Appraisal could be used to help tackle specific issues as well as large-scale assessments.

Current government policy (DH, 2010a,b) stresses the importance of a localised approach to community healthcare service provision. Each locality is different in terms of its characteristics, which might include its demography, geographical location, environment, amenities, transport systems, unemployment levels, deprivation scores, work opportunities and access to services, for example. As a result of these potential variations, it is important to interpret national guidelines according to local needs. Each locality will have its own individualised local targets for public health tailored to the specific requirements of the local population. Such targets are usually chosen following an examination of local information sources, such as epidemiological data collected by the relevant Public Health Department, general practice profiles and caseload analysis data obtained from local healthcare practitioners, for example. Roberson (2016), following a comprehensive review of the literature relating to caseload management by district nursing teams, concludes that effective and efficient caseload management is essential in improving the quality of care to patients, and ensuring that limited valuable resources are used in the most appropriate way.

By systematically reviewing local information sources and working within government/professional guidelines, community nurses have an opportunity to develop practice and more collaborative ways of working.

Example 1.1

From general practice profile information, one locality identified a significantly high percentage of the older population with dementia. As a result, the community psychiatric nurse team working with older people in the locality liaised with the district nurses and practice nurses across the identified GP practices with a view to discussing the provision of support for the carers involved.

DH (2010a) highlights the importance of frontline staff taking responsibility for implementing changes in the NHS. This will involve community nurses becoming more actively involved in health needs assessment. Within the public health reports from the four countries across the United Kingdom, it has been recognised that there are populations whose healthcare needs are unmet, which